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February 1, 2011

Charles LIttleton
Centers for Medicare & Medicaid Services
CMS,OAGM,AGG,DSPSCG
Attn: RFP-CMS-2011-0009/Charles Littleton
C2-21-15 Central Building
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Mr. Littleton,

Please accept this as Kentucky's proposal for the State Demonstration to Integrate Care for Dual Eligible Individuals. I am submitting this proposal on behalf of the Department for Medicaid Services.

Sincerely,

Neville J. Wise

Neville Wise
Acting Commissioner
Department for Medicaid Services

STATE DEMONSTRATIONS TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS

On November 16th, the Centers for Medicare and Medicaid Services (CMS) formally announced the establishment of the Center for Medicare and Medicaid Innovation. The Center is charged with exploring new health care delivery and payment models that will enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of the population, and lower costs through improvements centered on integration of care. These efforts come at a time of great activity by federal and state governments as they assess new opportunities provided under the federal health care reform legislation to redesign, reshape, and repurpose payment methodologies, medical care strategies, and collaboration in order to reexamine health care spending to lower costs, improve health care outcomes and be more efficient in the health care delivery systems.

Dual eligibles account for 16 to 18 percents of enrollees in Medicare and Medicaid, but roughly 25 to 45 percent of spending in these programs respectively. Approximately 9 million dual eligibles nationwide (96,000 in Kentucky, excluding Medicare savings program participants), 2.0 million in Kentucky, receive significant assistance with coverage of medical services in an uncoordinated system of care resulting in high costs that does not result in improved health outcomes. This application is to solicit funding for the development of an innovative service delivery and payment model that will integrate care for this population. The design model will be person-centered and will integrate acute, behavioral health, and long-term supports and services for dual eligible individuals with a goal of improving quality, coordination and cost-effectiveness of care. Special emphasis will be placed upon assuring that the model developed will lend itself to rapid testing; and, assuming successful demonstration can be replicated to other locations.

Description of Kentucky's Proposed Approach to Integrating Care

The Medicaid Program is jointly financed by the states and the federal government, with states being responsible for a significant portion of the program. With joint financing and coverage of almost 20 percent of Kentucky's population in the Medicaid program, Medicaid is the largest single budget item in the state budget generally, and, in terms of state General Fund expenditures, is second only to education funding. Policymakers are continually searching for methods to provide needed health care coverage at lower costs, as many other needs of the state, i.e., education; infrastructure investments, corrections, etc. vie for scarce state resources.

Medicare has several parts-Parts A, B, C and D. Eligibility to enroll in the parts varies, and the parts provide different coverage of medically necessary services. Medicare Part A is a type of hospital insurance. The coverage includes inpatient care in hospitals, nursing homes, skilled nursing facilities, and critical assess hospitals. It may, under certain conditions, also provide hospice or home health care services. Part A does not include long-term or custodial care. Part B of Medicare is a medical insurance plan offered by the federal government. Part B coverage includes medically necessary doctor's services, outpatient care, and most other services that Part A does not cover such as some physical or occupational therapies and some home health care

services. Part B covers some preventive services as well. Neither Parts A nor B cover everything, nor do they cover the total costs for many of the covered services or medical supplies. Most people do not have to pay a premium for Part A, but if they do, they may enroll by paying the premium. Conversely, most people have to pay a premium for Part B. Cost sharing in the form of deductibles and coinsurance may apply to the Part A and B services. For certain Medicare individuals, each state's Medicaid program may provide coverage for premiums, deductibles and co-insurance for lower incomes individuals. A person's income and resources will determine what assistance the state's Medicaid program will provide.

The following programs may provide Medicaid coverage for Medicare enrollees, hence the name "dual eligibles":

> Qualified Medicare Beneficiary (QMB) – Coverage of Medicare Part A deductible, Medicare Part B premium and Part B deductible, co-insurance for Part B, and for extended hospital stays and skilled nursing, in some cases, Part A premium, and the costs of Medicaid services not covered by Medicare.
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> Specified Low-Income Medicare Beneficiary Program (SLMB) – Medicare Part B premium and the costs of Medicaid services not covered by Medicare.
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> Qualifying Individual (QI) Program-Medicare Part B premium.
>
> Qualified Disabled and Working Individual (QDWI) - Medicare Part A premium.

These programs collectively are sometimes referred to as "Medicare Savings Programs". The programs have similar names but offer different benefits and different eligibility qualifications. In addition, other individuals maybe eligible for both Medicare and Medicaid based on meeting qualifications for eligibility enrollment.

There is considerable research that suggests that dual eligibles are disproportionately sicker, are disproportionately members of minority populations, and use more health care resources. Other characteristics include mental illness as an important component of the excess morbidity and spending of dual eligibles, and dual eligibles residing in nursing homes are the sickest subset of beneficiaries (Morden and Garrison, Jr., 2006).

With the U.S. population aging, population trends would indicate that there is need for primary care physicians in this country to provide higher-quality, more cost effective care to older citizens with chronic conditions. Maintaining these senior citizens with their highest possible functional state, for as long as possible, may reduce the need for or length of time that older citizens need long-term nursing care. While significant portions of the costs of inpatient hospital and outpatient medical services, including pharmacological care are generally covered by Parts A and B of Medicare (and now Part D of Medicare), the Medicaid program is the largest payor of expensive long-term nursing facility services. State policymakers grappling with the cost of nursing facility care for its residents should be interested in improving the outcomes of individuals with chronic illness. These individuals will most likely be seeking Medicaid coverage in a nursing facility at some point in their life, yet, the Medicare program is the primary

hospital insurance and medical insurance plan for many individuals in the early senior years (age 65 or earlier if disabled). Coordinated, integrated care for these seniors is a must if both the Medicare and Medicaid programs are to realize goals of quality care, maximum functional autonomy and quality of life for the beneficiaries, and efficient health care costs.

Public health insurance programs such as Medicare and Medicaid have become increasingly the focus of state and federal lawmakers as they seek to assure that the benefits provided under these publicly financed health care plans provide quality, efficient health care at reasonable costs. Between the two programs, health care spending now tops $12 billion annually in Kentucky. As costs continue to rise and the population continues to increase in age, there are significant opportunity costs involved in designing and implementing successful strategies to improve health outcomes of beneficiaries and to lower costs. For the most vulnerable of the population that is eligible for both programs, lower-income "dual eligibles", there is evidence to support that additional spending at the margin has no significant impact on health (Boyle, Lahey and Czervionke, December 2008).

Dual eligibles with multiple chronic conditions are heavier users of health care. When care is not coordinated across providers, they are more likely to receive duplicate tests, are at greater risk for conflicting treatment, experience higher rates of preventable hospitalizations and receive less preventive care, all of which contribute to higher costs (Lipson and Au). Care coordination strategies are designed to coordinate care across multiple provider and settings, encourage greater communication among providers, and provide more support for patients and the caregiver provider to manage their conditions. The goal of care coordination is to manage chronic disease in the hopes of improving health status and reducing costs.

In addition to many other Medicare Program reforms which will be implemented in the coming months, developing a model to coordinate the payments, the delivery of health care benefits and supports across multiple types of providers and across Medicaid and Medicare could significantly reduce unnecessary use of hospital services and decrease the use of institutional care over time. Analysis of this data would seem to indicate that dual eligibles could benefit from coordination of care designed to reduce use of emergency rooms and readmissions to the hospital and improve the transition of care from hospital to outpatient settings. Additionally, it is hypothesized that care coordination would improve health outcomes, functionality of patients, and delay need for institutionalization.

A review of Kentucky specific Medicaid data reveals that in Calendar Year 2009 there were 95,892 (excluding Medicare savings program participants) average monthly members with dual Medicaid and Medicare eligibility. Of these, 13,200 were covered under Medicaid Managed Care in a sixteen county region around Louisville. It is important to note that the Medicaid Managed Care partnership excludes individuals in long term care settings. The remaining 83,692 average monthly members were covered under standard fee for service Medicaid which includes members in institutional settings in the sixteen county managed care region as well as the remainder of the state.

Dually eligible Medicaid fee for service utilizing members average 62,511 monthly or 76 percent for the non managed care average monthly population and totaled $1.2 billion for Calendar Year 2009. The non-institutional managed care population having encounter expenditures or fee-for

service expenditures averaged 8,850 per month or 67 percent of average monthly members; expenditures for these members totaled $32 million.

Across both populations, and using both encounter data and claims data, 15.8 percent of average monthly members utilized Nursing Home care at a cost of $728 million which represented 57.8 percent of the population's calendar year cost of care in Medicaid. Other substantial cost services for this population in Calendar Year 2009 included Supports for Community Living Waiver ($149 million or 11.8% of costs), Institutional ICF/MR ($83 million or 6.6% of costs) and Inpatient Hospital ($42 million or 3.3% of costs). In addition to Nursing Home utilization, other highly utilized services include Pharmacy (44,463 average monthly or 46.4% rate), Physician (30,296 or 31.6%), Durable Medical Equipment (15,756 or 16.4%), and Outpatient Hospital (12,013 or 12.5%).

The Medicare claims data that we have for these dual eligible members totaled $825 million for Calendar Year 2009. Inpatient Hospital accounted for $336 million of this figure or 41 percent, Nursing Home care, Physician services, and Outpatient Hospital and Durable Medical equipment rounded out the five most expensive services for Medicare. Heavily utilized services for which Medicare paid included Physician (35,785 average monthly or 37.3% rate), Outpatient Hospital (18,791 or 19.6%); Durable Medical Equipment (14,166 or 14.8%), and Independent Lab Work (11,530 or 12.0%).

Kentucky proposes to develop a model of integrated care using care coordination strategies which will coordinate the payments and the delivery of health care benefits and supports across multiple types of providers across Medicaid and Medicare covered benefits. The model would be designed to reduce unnecessary use of hospital services and decrease the use of institutional care. A review of the research regarding effective strategies indicates that the effectiveness of an overall strategy will depend on making the best decision relative to that state's environment. The following care coordination strategies appear to have been most successful from a cost saving standpoint and will be incorporated into the model design (Libson and au, included in NGA Publication, "States roles in Delivery System Reform":

- Target high risk populations:
- Tailor services to individual patient needs;
- Provide sufficient in-person contact;
- Provide for regular communication between care coordinators and primary care physicians; and
- Provide timely information to providers on hospital admissions and emergency rooms.

The design features that will be explored and developed will include:

- How to target populations for the greatest financial gain
- The capacity of state staff versus use of outside contract assistance
- How to develop payment models to align payments to providers
- The specific care coordination strategies to be used
- How to engage the beneficiary
- How different medical provider structures affect the viability of the strategy
- What data needs to be collected to evaluate the success of the program

- How the use of Health Information Exchange and Electronic Health Records can be helpful to the overall care coordination strategy
- How to overcome challenges and align incentives between the two programs.

This proposal is designed to develop a model with proven care coordination strategies that are most likely to produce improved health outcomes and lower costs for both the Medicare and Medicaid programs with the lowest intervention costs. Primary goals are to coordinate the care of chronically ill individuals to reduce unnecessary hospital costs and delay the use of institutional services.

Overview of State Capacity and Infrastructure

The Cabinet for Health and Family Services (CHFS) in the Commonwealth of Kentucky is a large umbrella agency which houses the Public Health, Medicaid, Behavioral Health programs for the state as well as the adult and child protective services programs. Also included are the state administered, state supervised local office for eligibility intake and determination for TANF, Medicaid, SNAP, LIHEAP, and State Supplementation programs. The Cabinet has the essential personnel and related resources to support the design of the integrated demonstration proposal. The following Cabinet staff resources will be dedicated to the project: Senior Cabinet program and budget analysts, data analysts, Medicaid program eligibility and operations staff, Cabinet IT technical and development staff, Project Director and support staff.

Resources made available through this contract will be used to support planning and development costs, data gathering and analysis, and special programming costs. Existing contracts with external resources including actuarial and other consulting services will be utilized. Documentation of the development process and resulting deliverables will be prepared as a result of the contract.

Description of Current Analytic Capacity

The Kentucky Department for Medicaid Services will be the lead agency for the Demonstration and also has available Cabinet staff through other agencies within the Cabinet to assist with the project.

The CHFS has the available staff resources to provide contract oversight, program and policy development, budgetary development, oversight and monitoring, information systems hardware and software development and management. Working with Medicaid Program officials and staff and the Public Health office and staff, the Cabinet has the program, policy and clinical staff necessary to develop a model design of an innovative service delivery and payment models for dual eligible individuals. The Cabinet also has a high level policy and data analyst with previous experience in the Chief Economists office of the Legislative Research Commission who will assist with data analysis, projections, model design and evaluation.

Medicaid or Cabinet staff have experience in analyzing fee-for-service data and managed care encounter data. The Cabinet has access to both Medicaid and Medicare data, but will need to link both sets of data in order to conduct dual eligible specific analyses. The CHFS has

significant experience with using fee-for-service and encounter data from managed care plans, as well as obtaining actuarial analysis and certifications of rates for the managed care plans.

Summary of Stakeholder Environment

The Commonwealth has support of significant advocacy groups for this proposal including a large multi-coalition of organizations representing Medicaid beneficiaries, senior citizens, disabled citizens, persons with intellectual disabilities, mental health coalitions, etc. Additional work will need to be done to include beneficiaries, providers, Special Needs Plans, etc.

The CHFS recently issued six Requests for Information to solicit interest and capacity for innovative proposals in reforming the delivery systems for the Medicaid population. One of those Requests was for innovations in delivering long term care services and supports, including but not limited to, PACE programs. These efforts should complement the design work under this contract.

Timeframe

The timeframes for the deliverables is aggressive, but reasonable and the CHFS will be able to meet the proposed timeframes. No legislation is needed to carry out the functions under the contract.

Budget and Use of Funds

The following represents a breakdown of Kentucky's budget request of one million.

$250,000 – Staff for planning and development, includes salary and fringe costs. Provides for a project director, 1 Health Policy Specialist II, I program Coordinator and a data analyst (will utilize existing data analyst – part time).

$25,000 – Travel costs, includes travel to HHS and other meetings and/or conferences concerning dual eligible's, in addition to in-state- travel costs for events and meetings.

$325,000 – actuarial support for analysis.

$300, 000 – IT costs for development and special programming.

$84,000 – Indirect cost to Kentucky for administration of the demonstration funds.

$16,000 – Office equipment includes, computer, office furniture, phone and supplies.